

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12381

12394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federsburg - Rural		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithville Road		e. STREET ADDRESS Smithville Road	
3. NAME OF DECEASED (Type or print) First Anthony Middle Dorman Last Dorman		4. DATE OF DEATH Month November Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1911
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics, Inc. Sanderson, Florida	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerry Dorman		14. MOTHER'S MAIDEN NAME Ellen (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-6880	
17. INFORMANT Mrs. Miriam F. Dorman, Federsburg, Md., R. 10		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1/54 19 54 , to 11/20 19 59 , that I last saw the deceased alive on 11/20 19 59 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Anderson		ADDRESS (Street, city or town, state) Federsburg, Maryland	
PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.		DATE SIGNED 11-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frempton and Son, Federsburg, Maryland		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
24b. REGISTRAR'S SIGNATURE Carlton S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

12382

12395

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>RIDGELEY</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELEY MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FRED</u> First <u>H.</u> Middle <u>FLOUNDERS</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>20</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER OF TRAINING HORSE</u>		11. BIRTHPLACE (State or foreign country) <u>QUEEN ANN Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>RICHARD CARTEP FLOUNDER</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH MURPHY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Fred Flounder</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the mouth & throat</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive leukoplakia of the mouth</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 15</u> , 19 <u>59</u> , to <u>Nov. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 20</u> , 19 <u>59</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.		ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>Nov. 21, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>	22b. DATE THEREOF <u>Nov 22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENSBORO</u>	22d. LOCATION (City, town, or county) (State) <u>GREENSBORO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u> ADDRESS <u>Sentow, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Place of Issue		Signature of Issuing Officer	

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 1913

CERTIFICATE OF DEATH

12383

Reg. Dist. No.

12396

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely			c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Alpheus Alexander Horney, Sr.				4. DATE OF DEATH Month Day Year November 7 19 59				
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1876		
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alpheus Horney				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 040-20-0523		17. INFORMANT Alpheus Horney		Address West Haven, Conn.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 1954 to Nov. 7 1959 , that I last saw the deceased alive on Nov. 7 1959 , and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ridgely, Md. DATE SIGNED 11/7/59								
ACTUAL SIGNATURE Charles H. Winnacott M.D.				PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59		22c. NAME OF CEMETERY OR CREMATORY Hillsboro Greenmount Hillsboro, Maryland		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Rawlings				ADDRESS Hillsboro and		24a. REC'D BY REGISTRAR DATE NOV 10 '59		
				24b. REGISTRAR'S SIGNATURE William L. Hines				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro				c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro			
f. STREET ADDRESS None				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Hudson Last Hudson				4. DATE OF DEATH Month November Day 18 Year 1959			
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-1879	
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner				10b. KIND OF BUSINESS OR INDUSTRY Farm			
13. FATHER'S NAME Samuel Hudson				14. MOTHER'S MAIDEN NAME Louise Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-36-0922			
17. INFORMANT Altha Hudson				Address Goldsboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Prostate with 177x DUE TO metastasis to the hips Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastasis to the hips (c) metastasis to the hips							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia (nutritional)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 12, 1959 to Nov. 18, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 11/19/59							
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.				PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais				ADDRESS Greensboro, Md.			
24a. REC'D BY REGISTRAR NOV 23 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Adams			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>25</u></p>	
<p>5. Place of birth: <u>John Doe</u></p>		<p>6. Date of death: <u>Jan 1, 1925</u></p>	
<p>7. Cause of death: <u>John Doe</u></p>		<p>8. Date of death: <u>Jan 1, 1925</u></p>	
<p>9. Place of death: <u>John Doe</u></p>		<p>10. Date of death: <u>Jan 1, 1925</u></p>	
<p>11. Name of physician: <u>John Doe</u></p>		<p>12. Date of death: <u>Jan 1, 1925</u></p>	
<p>13. Name of physician: <u>John Doe</u></p>		<p>14. Date of death: <u>Jan 1, 1925</u></p>	
<p>15. Name of physician: <u>John Doe</u></p>		<p>16. Date of death: <u>Jan 1, 1925</u></p>	
<p>17. Name of physician: <u>John Doe</u></p>		<p>18. Date of death: <u>Jan 1, 1925</u></p>	
<p>19. Name of physician: <u>John Doe</u></p>		<p>20. Date of death: <u>Jan 1, 1925</u></p>	
<p>21. Name of physician: <u>John Doe</u></p>		<p>22. Date of death: <u>Jan 1, 1925</u></p>	
<p>23. Name of physician: <u>John Doe</u></p>		<p>24. Date of death: <u>Jan 1, 1925</u></p>	
<p>25. Name of physician: <u>John Doe</u></p>		<p>26. Date of death: <u>Jan 1, 1925</u></p>	
<p>27. Name of physician: <u>John Doe</u></p>		<p>28. Date of death: <u>Jan 1, 1925</u></p>	
<p>29. Name of physician: <u>John Doe</u></p>		<p>30. Date of death: <u>Jan 1, 1925</u></p>	
<p>31. Name of physician: <u>John Doe</u></p>		<p>32. Date of death: <u>Jan 1, 1925</u></p>	
<p>33. Name of physician: <u>John Doe</u></p>		<p>34. Date of death: <u>Jan 1, 1925</u></p>	
<p>35. Name of physician: <u>John Doe</u></p>		<p>36. Date of death: <u>Jan 1, 1925</u></p>	
<p>37. Name of physician: <u>John Doe</u></p>		<p>38. Date of death: <u>Jan 1, 1925</u></p>	
<p>39. Name of physician: <u>John Doe</u></p>		<p>40. Date of death: <u>Jan 1, 1925</u></p>	
<p>41. Name of physician: <u>John Doe</u></p>		<p>42. Date of death: <u>Jan 1, 1925</u></p>	
<p>43. Name of physician: <u>John Doe</u></p>		<p>44. Date of death: <u>Jan 1, 1925</u></p>	
<p>45. Name of physician: <u>John Doe</u></p>		<p>46. Date of death: <u>Jan 1, 1925</u></p>	
<p>47. Name of physician: <u>John Doe</u></p>		<p>48. Date of death: <u>Jan 1, 1925</u></p>	
<p>49. Name of physician: <u>John Doe</u></p>		<p>50. Date of death: <u>Jan 1, 1925</u></p>	
<p>51. Name of physician: <u>John Doe</u></p>		<p>52. Date of death: <u>Jan 1, 1925</u></p>	
<p>53. Name of physician: <u>John Doe</u></p>		<p>54. Date of death: <u>Jan 1, 1925</u></p>	
<p>55. Name of physician: <u>John Doe</u></p>		<p>56. Date of death: <u>Jan 1, 1925</u></p>	
<p>57. Name of physician: <u>John Doe</u></p>		<p>58. Date of death: <u>Jan 1, 1925</u></p>	
<p>59. Name of physician: <u>John Doe</u></p>		<p>60. Date of death: <u>Jan 1, 1925</u></p>	
<p>61. Name of physician: <u>John Doe</u></p>		<p>62. Date of death: <u>Jan 1, 1925</u></p>	
<p>63. Name of physician: <u>John Doe</u></p>		<p>64. Date of death: <u>Jan 1, 1925</u></p>	
<p>65. Name of physician: <u>John Doe</u></p>		<p>66. Date of death: <u>Jan 1, 1925</u></p>	
<p>67. Name of physician: <u>John Doe</u></p>		<p>68. Date of death: <u>Jan 1, 1925</u></p>	
<p>69. Name of physician: <u>John Doe</u></p>		<p>70. Date of death: <u>Jan 1, 1925</u></p>	
<p>71. Name of physician: <u>John Doe</u></p>		<p>72. Date of death: <u>Jan 1, 1925</u></p>	
<p>73. Name of physician: <u>John Doe</u></p>		<p>74. Date of death: <u>Jan 1, 1925</u></p>	
<p>75. Name of physician: <u>John Doe</u></p>		<p>76. Date of death: <u>Jan 1, 1925</u></p>	
<p>77. Name of physician: <u>John Doe</u></p>		<p>78. Date of death: <u>Jan 1, 1925</u></p>	
<p>79. Name of physician: <u>John Doe</u></p>		<p>80. Date of death: <u>Jan 1, 1925</u></p>	
<p>81. Name of physician: <u>John Doe</u></p>		<p>82. Date of death: <u>Jan 1, 1925</u></p>	
<p>83. Name of physician: <u>John Doe</u></p>		<p>84. Date of death: <u>Jan 1, 1925</u></p>	
<p>85. Name of physician: <u>John Doe</u></p>		<p>86. Date of death: <u>Jan 1, 1925</u></p>	
<p>87. Name of physician: <u>John Doe</u></p>		<p>88. Date of death: <u>Jan 1, 1925</u></p>	
<p>89. Name of physician: <u>John Doe</u></p>		<p>90. Date of death: <u>Jan 1, 1925</u></p>	
<p>91. Name of physician: <u>John Doe</u></p>		<p>92. Date of death: <u>Jan 1, 1925</u></p>	
<p>93. Name of physician: <u>John Doe</u></p>		<p>94. Date of death: <u>Jan 1, 1925</u></p>	
<p>95. Name of physician: <u>John Doe</u></p>		<p>96. Date of death: <u>Jan 1, 1925</u></p>	
<p>97. Name of physician: <u>John Doe</u></p>		<p>98. Date of death: <u>Jan 1, 1925</u></p>	
<p>99. Name of physician: <u>John Doe</u></p>		<p>100. Date of death: <u>Jan 1, 1925</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12385

12398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS Park Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle Davis Last Jefferson		4. DATE OF DEATH Month November Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward F. Davis		14. MOTHER'S MAIDEN NAME Laura Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Donald E. Jefferson, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General carcinomatosis 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of liver DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1935 to Nov. 20 , 19 59 , that I last saw the deceased alive on Nov. 20 , 19 59 , and that death occurred at 7:30P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 11-23-59 ACTUAL SIGNATURE W. K. Knotts M.D. PHYSICIAN'S NAME (Type) W. K. Knotts, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 23, 1959	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR NOV 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **12386**

**FOR STATE
HEALTH DEPT.**

12399

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		
c. LENGTH OF STAY IN 1b <u>Life</u>			d. STREET ADDRESS <u>R.F.D. Rt. 1.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD Rt. 1.</u>					
3. NAME OF DECEASED (Type or print) <u>Matthew</u>			4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Gal</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/12/89</u>		9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Moses Johns</u>			
14. MOTHER'S MAIDEN NAME <u>Leah Hutchins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Corie Johns, Ridgely, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u> </u> DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>2 mo -</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dawson D. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-20-59</u>	
EXAMINER'S NAME (Type) <u>DAWSON D. GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>	
22d. LOCATION (City, town, or county) <u>Denton</u>		22e. (State) <u>Md.</u>		22f. (City or town) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. D. Collier, Denton, Md.</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>REC 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

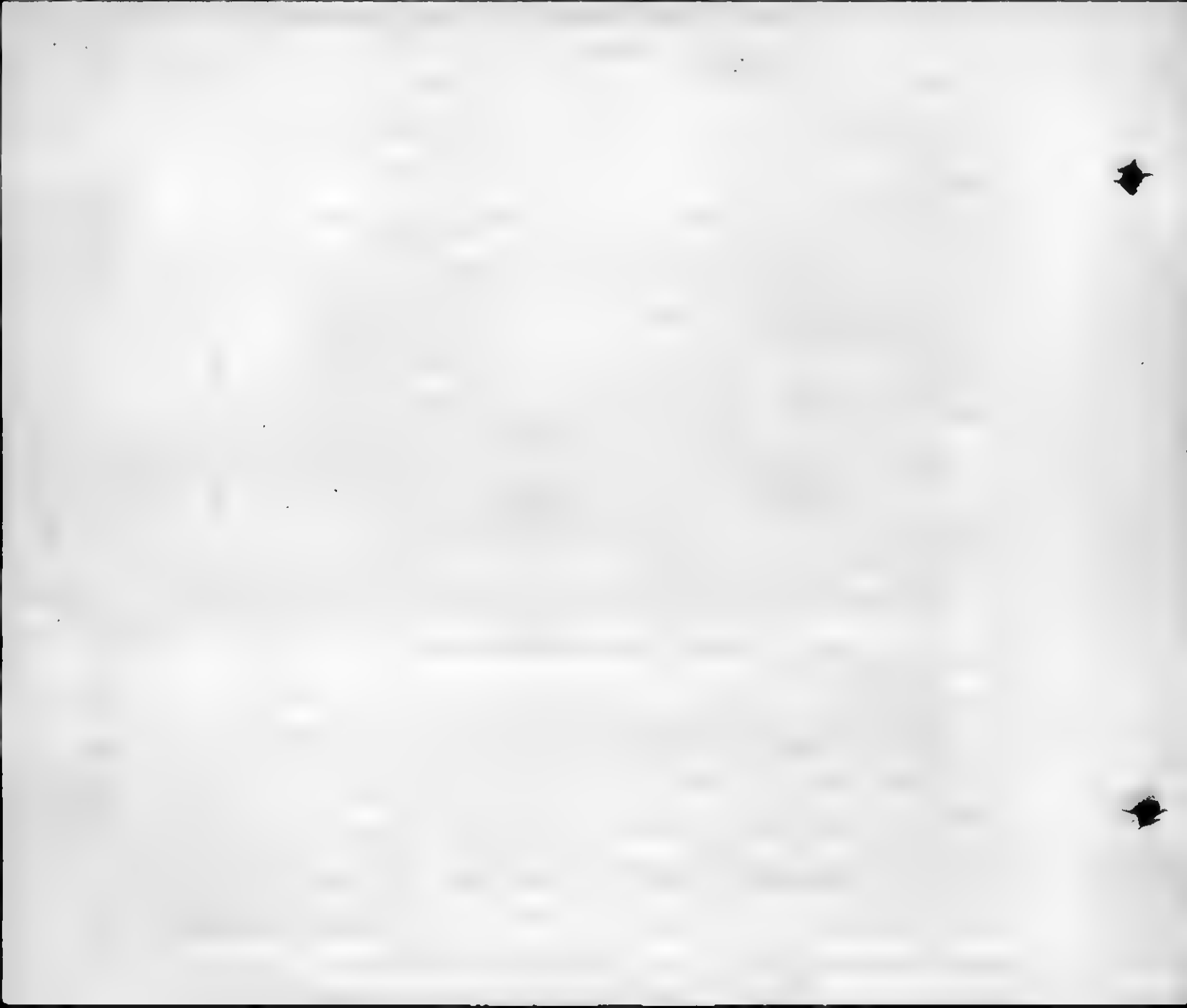
12387

12400

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RIDGELY	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AGNES EMMA LANE		4. DATE OF DEATH Month Day Year NOV. 11 1959	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6-1888
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN GAITLEY		14. MOTHER'S MAIDEN NAME ALICE BRIGHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT FRANK LANE		Address RIDGELY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis (c) Arteriosclerosis - Hypertension			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours Several yrs. Several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April - 1950 to Nov. 11 , 19 59 , that I last saw the deceased alive on Nov. 11 , 19 59 , and that death occurred at 9 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Winnacott M.D.		ADDRESS (Street, city or town, state) Ridgely, Md.	
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT		DATE SIGNED 11/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF NOV. 14	22c. NAME OF CEMETERY OR CREMATORY CENTREVILLE	22d. LOCATION (City, town, or county) (State) CENTREVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

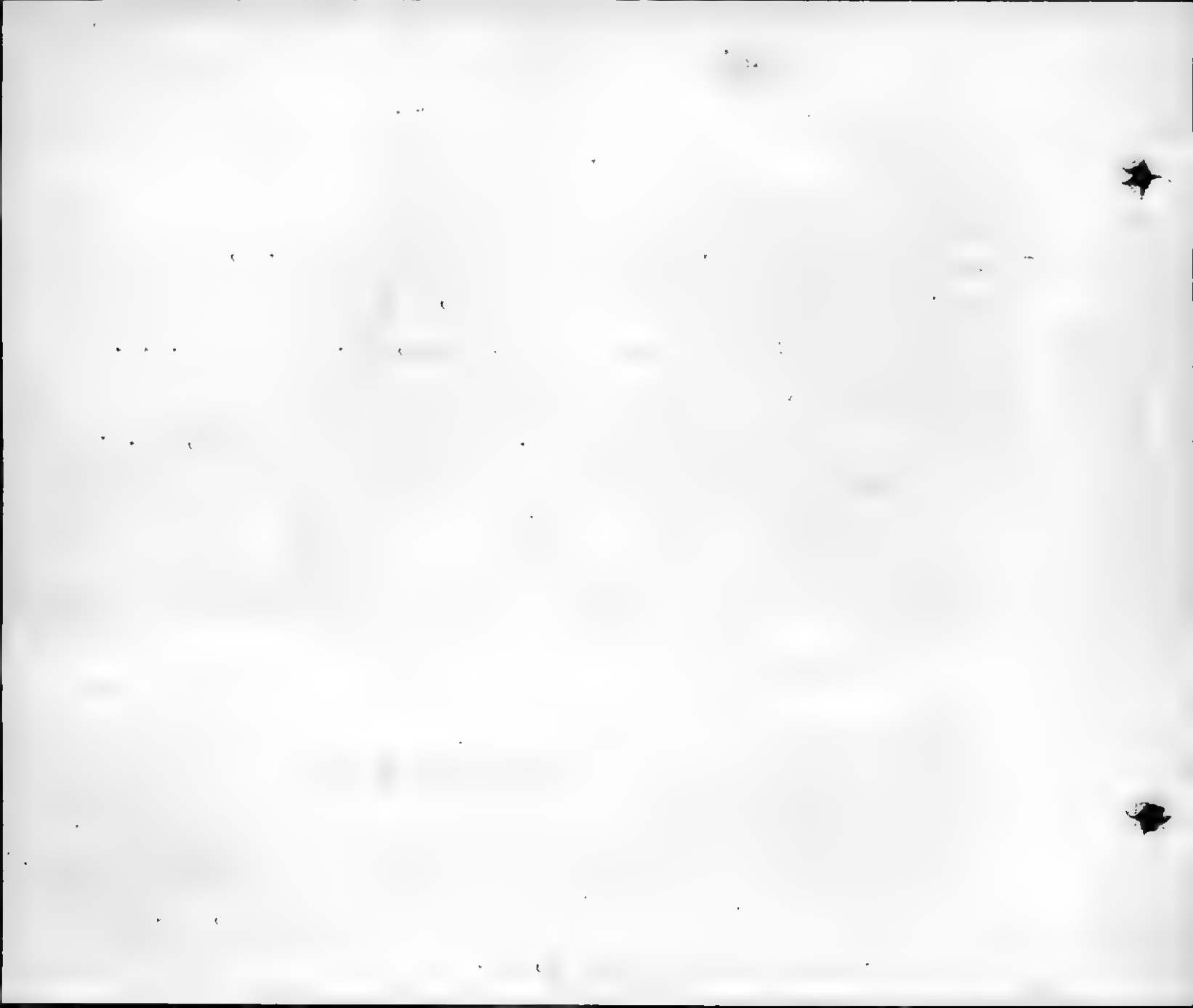
12388

12401

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hickman		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olen T. Middle Melvin Last ~		4. DATE OF DEATH Month Nov. Day 2, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1884
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store manager- factory work		10b. KIND OF BUSINESS OR INDUSTRY Hickman, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Melvin		14. MOTHER'S MAIDEN NAME Cecelia Noble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. informant	
17. ADDRESS Mrs. Bessie Melvin Denton, Md. RFD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 29, 1959 to Nov. 2, 1959 that I last saw the deceased alive on Nov. 2, 1959 and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Metzler, Jr. M.D.		DATE SIGNED Nov. 2, 1959	
PHYSICIAN'S NAME (Type) G. Metzler, Jr. M.D.		ADDRESS (Street, city or town, state) Main + Market Sts., Bridgeville, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/5/1959	
22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Shannon S. Williams		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12402

CERTIFICATE OF DEATH

Reg. Dist. No.

12389

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 3 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle Mae Last Patrick				4. DATE OF DEATH Month 11 Day 19 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-10-1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Hickson				14. MOTHER'S MAIDEN NAME ? Neighbors			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Medford J. Benney Address Centerville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dts. with hypertension (c) General Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1959 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 1, 1958 , to Nov. 19, 1959 , that I last saw the deceased alive on Nov. 18, 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED Nov. 20, 1959							
ACTUAL SIGNATURE Charles H. Stonesifer M.D.				PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY Chesterfield		22d. LOCATION (City, town, or county) (State) Centerville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleis ADDRESS Greensboro, Md.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1905

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1860		Maryland	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		2 Weeks		10:00 AM	
Occupation		Education		Marital Status		Religion		Usual Residence	
Teacher		High School		Married		Catholic		123 Main St, Baltimore	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Manner of Death		Remarks	
Jan 15, 1905		10:00 AM		Home		Natural		None	

1

12403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
c. LENGTH OF STAY IN 1b 10 years		d. STREET ADDRESS Denton Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Denton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harrison Middle Henry Last Trice		4. DATE OF DEATH Month November Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1888 71 yrs.
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Trice		14. MOTHER'S MAIDEN NAME Martha Rosser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 214-30-8984	
17. INFORMANT Mrs. Ralph D. Lord, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Coronary Atherosclerosis) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Adeno Carcinoma Lung DUE TO (c) July 21, 59		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21-1959 to Nov-2-1959 , that I last saw the deceased alive on Nov. 2-1959 , and that death occurred at 1:30P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Lennon M.D.		ADDRESS (Street, city or town, state) Federalsburg Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) W. E. Lennon MD		Federalsburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 4, 1959	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR NOV 5 '59	24b. REGISTRAR'S SIGNATURE Carlton P. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH RECORD

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Blank form with horizontal lines for data entry.